BEFORE THE
PHYSICIAN ASSISTANT BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 1E-2007-186259
DAVID ORTIZ, P.A.,	OAH Case No. 2010020018
Physician Assistant License No. PA 11186	
Respondent.	

ORDER OF NON-ADOPTION OF PROPOSED DECISION AFTER REMAND

Pursuant to Government Code section 11517, the attached Proposed Decision After Remand of the Administrative Law Judge dated June 3, 2015, in the above-entitled matter has been rejected or **non-adopted.** The Physician Assistant Board will decide the case upon the record, including the transcript and exhibits of the hearing held on May 4, 2015, and upon such written argument as the parties may wish to submit. The Board is particularly interested in arguments directed to the following questions: (1) whether there are grounds for discipline in this case, and if so, what level of discipline would be appropriate to protect the public; and, (2) whether Respondent may, for the purposes of explaining the circumstances surrounding his guilty plea and why he entered such plea, be permitted to challenge or attack the record that he entered a guilty plea. The parties will be notified of the date for submission of such argument when the transcript of the above-mentioned hearing becomes available.

To order a copy of the transcript, please contact Kennedy Court Reporters, 920 West 17th Street, 2nd Floor, Santa Ana, CA 92706. Their telephone number is (800) 231-2682. To order a copy of the exhibits, please submit a written request to this Board.

Please do not attach to your written argument, any new evidence or documents that are not part of the record. The Board has not ordered the taking of new or additional evidence. Consequently, any documents that are not part of the administrative record cannot be considered by the Board.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Board. The Board's mailing address is as follows:

MEDICAL BOARD OF CALIFORNIA
Attention: Kristy Voong
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-3831
(916) 576-3216

IT IS SO ORDERED this 10th day of July, 2015

Robert E. Sachs, P.A., Chair
Physician Assistant Board

BEFORE THE
PHYSICIAN ASSISTANT BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: DAVID ORTIZ, P.A., Physician Assistant License Number 11186, Respondent.	Case No. 1E-2007-186259 OAH Case No. 2010020018

PROPOSED DECISION AFTER REMAND

This matter regularly came for hearing before Samuel D. Reyes, Administrative Law Judge, Office of Administrative Hearings, on May 4, 2015, in Los Angeles, California.

Megan R. O'Carroll, Deputy Attorney General, represented Glenn L. Mitchell, Jr. (Complainant), Executive Officer of the Physician Assistant Board (Board).[1]

Alexander W. Kirkpatrick, Attorney at Law, represented David Ortiz, P.A. (Respondent).

Complainant seeks to discipline Respondent's license on grounds of alleged sexual misconduct with one patient, M.W.,[2] and on the grounds of gross negligence, repeated negligent acts, prescribing without medical indication, excessive prescribing, failure to maintain adequate and accurate medical records, and practicing beyond the scope of his authority, in connection with the care and treatment of one patient, J.M. Respondent denied engaging in any sexual misconduct, asserted that he provided appropriate care to J.M., and argued that cause for discipline does not exist.

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[1] The Accusation in this matter was filed on January 9, 2009, by Elberta Portman, Executive Officer of the Board's predecessor Physician Assistant Committee, Medical Board of California (Committee). The Committee became the Board effective January 1, 2013, pursuant to Stats. 2012, ch. 332 (SB 1236), now codified in Business and Professions Code section 3501 (unless otherwise specified, all further statutory references are to the Business and Professions Code). All further references are to the Board.

[2] Initials have been used to protect the confidentiality of patients.

As more fully set forth below, a Proposed Decision issued on September 13, 2010, suspending Respondent's license for six months, staying the suspension, and placing the license on probation for three years on specified terms and conditions. The Board declined to adopt the Proposed Decision, made its own findings of fact and conclusions of law, and revoked Respondent's license. Respondent thereafter sought relief in the Superior Court of California, County of Sacramento (Court). On December 5, 2014, the Court issued a Peremptory Writ of Mandate (Writ) commanding that Respondent be allowed to present evidence regarding the circumstances of his guilty plea in 2008 involving patient M.W., that new findings be made after receipt of such evidence, that findings be made regarding whether Respondent's recordkeeping fell below the standard of care, and that the Board reconsider the penalty in light of any new findings it makes. On January 17, 2015, the Board issued an Order of Remand to Administrative Law Judge (Remand Order) in accordance with the Court's Writ.

Without objection, Complainant amended paragraph 37 of the Accusation to delete references to paragraph numbers 23 through 25 and 28 through 35.

Oral and documentary evidence and argument were received at the hearing, and matter was submitted for decision on May 4, 2015.

PROCEDURAL HISTORY

The Proposed Decision issued on September 13, 2010. Cause for discipline was found pursuant to sections 2234, subdivision (b), and 3527, subdivision (a), in that Respondent engaged in gross negligence in his care and treatment of J.M. by failing to obtain patient-specific authorization from Respondent's employer, Raymond Helston, M.D. (Helston), for several controlled substance prescriptions; pursuant to sections 3502, subdivision (a), and 3502.1, in that he prescribed controlled substances to J.M. without first obtaining patient-specific authorization from Dr. Helston; and pursuant to sections 2266 and 3527, subdivision (a), in that he failed to maintain adequate records in connection with the care and treatment provided to J.M. Based on the foregoing causes for discipline, Respondent's license was suspended for six months, which suspension was stayed, and the license was placed on probation for three years on specified terms and conditions.

As pertinent to the remand, the undersigned concluded in the Proposed Decision that cause for discipline did not exist pursuant to section 726 because it was not established by clear and convincing evidence that Respondent had engaged in acts of sexual misconduct. In this regard, the testimony of Respondent was credited over that of his accuser, M.W. Evidence of Respondent's June 28, 2008 conviction for violation of Penal Code section 243.4, subdivision (c) (sexual battery), which occurred pursuant to Respondent's plea of guilty, was deemed insufficient, even in light of M.W.'s testimony, to establish the truth of the allegations that Respondent inappropriately touched M.W. In brief, Respondent believed that he was pleading "no contest" and that he was not admitting guilt, the plea was entered by his attorney, and the plea resulted in a deferred entry of judgment.

On November 19, 2010, the Board declined to adopt the Proposed Decision and sought written argument from the parties on whether the proposed penalty should be modified.

On March 11, 2011, the Board issued its Decision After Non-Adoption (Decision). The Decision incorporated the factual findings and legal conclusions contained in the Proposed Decision with the following material changes. Factual finding number 33 was rewritten, and findings crediting Respondent's testimony were replaced with the following findings: "Given his plea of guilty in the criminal case, Respondent's denial of any inappropriate touching was not credible. . . . In the existing circumstances, therefore, M.W.'s testimony, coupled with Respondent's plea of guilty, is sufficient to establish that [R]espondent touched her in an inappropriate sexual manner." (Exh. 30, at pp. 60-61.) Factual finding number 34d was also rewritten, to read as follows:

"d. Respondent's plea, as entered by the person with apparent authority to do so, is deemed an admission of the facts set forth in count 2. Page 9 of Exhibit 11 (Page 9), reflecting a hearing held in Kern County Superior Court, specifies that Respondent [Defendant] entered a plea of guilty with [*sic*] regarding Count 2. Page 9 also specifies that Respondent voluntarily and intelligently waived his rights to a trial by the court or a jury, the right to confront witnesses and cross-examine them, the right to remain silent and the right against self-incrimination. Finally, Page 9 specifies that Respondent understood the nature and extent of the punishment that can result from a plea of guilty.

"The [Board] will not inquire as to the reasons Respondent entered his plea or the circumstances surrounding the plea. This admission is sufficient to overcome Respondent's denials that he touched patient M.W. in an inappropriate manner." (Exh. 30, at p. 61.)

The Board modified factual finding number 39, which found that the Board had incurred reasonable cost of investigation and enforcement in the sum of $1,261, by adding the following sentence: "These costs will be due if Respondent ever petitions for reinstatement and shall be paid prior to reinstatement of his license." (Exh. 30, at p. 63.) Legal conclusions numbers 1, 6, and 11 were modified to conclude that cause for discipline exists pursuant to section 726 in that it was established that Respondent engaged in acts of sexual misconduct and to conclude that revocation of Respondent's license was necessary for the protection of the public. The Board ordered revocation of Respondent's license.

On April 6, 2011, the Board granted a stay of its order revoking Respondent's license to consider Respondent's Request for Reconsideration of Decision and Request for Stay of Effective Date of Decision (Petition for Reconsideration). On April 18, 2011, the Board denied the Petition for Reconsideration and revoked Respondent's license.

On May 15, 2011, Respondent filed a Verified Petition for Writ of Administrative Mandate Following Decision After Non-Adoption Imposing Revocation of License (Writ Petition). On June 9, 2014, the Court issued its Order After Hearing on Petition for Writ of Mandate (Court Order). The Court granted the Writ Petition in part and denied it in part. It sustained the discipline for Respondent's failure to obtain patient-specific authorization from

Dr. Helston. With respect to the sexual misconduct, the Court concluded that the Board had committed legal error by relying exclusively on the guilty plea to find that Respondent engaged in sexual misconduct. The Court also concluded that because the Board can consider Respondent's plea as a factor in making its factual findings, and because Respondent had not been given the opportunity to present facts surrounding the nature of the charge and the plea or to explain why he entered into such a plea, the matter must be remanded for findings regarding the sexual misconduct allegations.

The Court concluded that the finding that Respondent failed to maintain adequate records was not supported by its findings. The Court wrote:

"The [Board] found [Respondent] violated Business and Profession[s] Code section 2266 by failing to maintain adequate records of his care and treatment of J.M. on July 8, 2004. (Fact 17; Conclusion 5.) Section 2266 provides: 'The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.' Section 2266 does not define what is required for an adequate record. Instead, the adequacy of a record must be judged against the professional standard of care – what records do other medical providers keep in similar circumstances? (See, e.g., *Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 271-72.) Unless it would be obvious to a layperson, the adequacy must be established by expert testimony. (See, e.g., *Landeros v. Flood* (1976) 17 Cal.3d 399, 410 [courts do not possess specialized knowledge necessary to resolve standard of care issues, which are 'peculiarly within the knowledge of experts'].

[¶] . . . [¶]

"However, the [Board] made no findings regarding the standard of care on this issue. It is not obvious to the court whether [Respondent]'s failure to note the two 'pertinent' facts in J.M.'s medical record violated the standard of care. The [Board] made extensive finding[s] about the standard of care with respect to [Respondent]'s care and treatment of J.M. (See Findings 21-25.) But it made no findings whether the standard of care required [Respondent] to specifically document (1) J.M. had been hospitalized and (2) [Respondent] told a nurse to obtain hospital records." (Exh. 30, at pp. 232-233.)

In the December 5, 2014 Writ, the Court commanded the Board, in pertinent part "To allow [Respondent] to present evidence regarding the circumstances surrounding his guilty plea, and then to make new findings consistent with the Order After Hearing on Petition for Writ of Mandate. The [Board] should also make findings on whether Petitioner's recordkeeping fell below the standard of care. [The Board] should reconsider the penalty in light of any new findings it makes." (Exh. 30, at p. 237.)

On January 27, 2015, the Board issued the Remand Order, stating, in pertinent part:

"Consistent with the Court's December 5, 2014 Writ order, the Board hereby remands this matter to the Office of Administrative Hearings to assign it to an administrative law judge to do the following:

"A) allow Respondent to present evidence regarding the circumstances surrounding the guilty plea and then make new findings consistent with the Court's ruling set forth in Exhibit 'B';

"B) make findings on whether Respondent's recordkeeping fell below the standard of care; and,

"C) reconsider the penalty in light of any new findings the Administrative Law makes.

"The Administrative Law Judge will forward his or her Proposed Decision to the Board for decision and action." (Exh. 30, at p. 243.)

EVIDENCE SUBMITTED ON REMAND AND DISCUSSION

Complainant offered Exhibit 30, which contained documents detailing the procedural history set forth above, and Respondent offered Exhibits H, a brief submitted before the Court, and G, a copy of the full Register of Actions/Docket in Case BM733517A before the Superior Court, Metropolitan Justice Building, County of Kern, State of California. The three exhibits were received into evidence, Exhibits 30 and H as jurisdictional documents. The parties also submitted written argument, Complainant's Prehearing Brief and Respondent's Hearing Brief, which have been marked for identification only as Exhibits 31 and F, respectively. Respondent testified about the circumstances surrounding his entry of the guilty plea.

At the hearing on remand, Respondent continued to maintain his innocence, and again denied touching M.W. in any inappropriate manner. He testified that sexually abusing anyone was repugnant to him.

Respondent explained that he entered into the plea on the advice of his attorney. Respondent was represented in the criminal case by Benjamin Greene (Greene) and others in his office, including Thomas Casa (Casa). During a conversation in the attorneys' office, Casa recommended that Respondent plead "no contest." Casa further explained that if Respondent did not get into trouble for two years the matter would go away. Respondent asked if pleading "no contest" was like pleading guilty. As Respondent recalled, Casa was "emphatic" that it was not like pleading guilty. Casa said the plea would be better because the case would disappear. Casa told Respondent that there was always the small possibility that he could lose the case, so it was better to take the plea. Casa also reported having discussed the matter with the judge, and that the plea terms were acceptable. Respondent testified that he authorized his attorney to enter a plea of no contest and that he would not have authorized him to enter a guilty plea on his behalf.

Respondent was also concerned about the impact continuing proceedings would have on his finances and his employment opportunities. He was not working at the time of the discussion with Casa, and lacked the funds to proceed to trial. In addition, he was looking for employment and did not want potential employers or others to read about his case in the newspapers.

Respondent's testimony was corroborated by the docket in the criminal matter. Respondent was not present during any of the ten pre-guilt-plea court hearings in his criminal case, and Greene or one of his associates entered an appearance on Respondent's behalf each time. On February 4, 2009, Casa entered a plea of guilty to one of the two counts, number 2, for violation of Penal Code section 243.4, subdivision (e)(1) (sexual battery). The docket states that "Defendant through his attorney is advised of these following rights and all are waived." (Exh. G., at p. 9.) Sentencing was set for February 7, 2012, as was a hearing on conditional dismissal of the case. As set forth in the docket, "Case to be dismissed if there are no further violations of the law." (Exh. G., at p. 9.)

On February 7, 2012, Respondent was present in the Superior Court, Metropolitan Justice Building, County of Kern, and was represented by Greene. The court docket contains the following entry: "[T]he court makes the following findings and/or orders: [¶] Motion to withdraw guilty plea is granted. Not Guilty plea entered as to Count 2. [¶] Count 2 dismissed on motion of the District Attorney. Reason for dismissal or discharge: furtherance of justice (PC 1385). [¶] . . . [¶]" (Exh. G, at p. 10.)

Respondent's testimony at the hearing on remand was consistent with his testimony at the initial hearing, albeit more detailed. He continued to present good demeanor, his answers were internally consistent, and his testimony was independently corroborated by the information in the court docket.

Respondent's testimony clearly and persuasively establishes that he did not intend to admit guilt and that he did not believe he was entering a guilty plea. He did agree to plead no contest on advice of counsel because he believed that he would not be admitting guilt, because he was told the case would go away without adverse consequences, and because he wanted to avoid the negative impact of a trial, including the adverse publicity, the expenditure of unavailable funds, and the possibility that he may lose. Pursuant to the plea agreement, the criminal court deferred imposing any penalty, which indicates that neither the prosecutor nor court believed Respondent was a sexual predator or that he warranted immediate punishment. On February 7, 2012, the guilty plea was in fact withdrawn, a not guilty plea was entered, and Count 2 was dismissed. In the existing circumstances, the guilty plea is given little or no weight and is insufficient, even with the testimony of M.W., to overcome Respondent's contrary testimony that he did not inappropriately touch M.W.

Complainant argued that it was not reasonable for Respondent to believe that the matter would simply go away, that he would be permitted to plead no contest, or that he would not be admitting to the underlying facts. On the contrary, it was reasonable for someone not having been previously involved with the criminal system to rely on his attorney's advice. In fact,

Respondent credibly testified that Casa was "emphatic" on his recommendation. Moreover, Respondent's understanding of his attorney's explanation is not too far from what actually happened, a deferred entry of judgment followed by dismissal of the charges.

In the Court Order, the Court concluded that section 2266 requires a finding that Respondent deviated from the standard of care. Complainant did not present any expert testimony regarding the records other medical providers keep in similar circumstances, and, therefore, did not establish that Respondent deviated from the standard of care in his recordkeeping.

In light of the Court Order and the new evidence received at the hearing on remand, factual finding numbers 2, 17, 33, 34, and 39, legal conclusion numbers 1, 5, 6, and 11, and the Order in the Board's Decision have been modified, or in the case of factual finding number 17c and portions of factual finding number 34, added, to reflect the Court Order and evidence received on remand. Formatting changes have also been made throughout the Decision.

FACTUAL FINDINGS

1. Complainant filed the Accusation on January 9, 2009, acting in her official capacity.

2. On August 16, 1982, the Board issued Physician Assistant License number PA-11186 to Respondent. Except for the instant matter, the license had not been previously disciplined. The license was revoked effective April 18, 2011.

Respondent's Background and Experience

3. Respondent has been working in the health care field most of his professional life. In 1966, he graduated from the pharmacy program at the Brook Army Medical Center. He remained in the military service, where he also received respiratory care training. In 1981, Respondent graduated from the physician assistant program at Stanford University.

Respondent's Employment with Dr. Helston

4. Respondent commenced his employment with Dr. Helston in 2002. At the time, Dr. Helston operated the Random Medical Clinic, which changed its name to the Sunrise Clinic a few years later. In addition to his physician assistant duties, Respondent was given a business role to help turn around the practice's financial situation. As part of a restructuring plan, Respondent agreed to defer a portion of his salary until the finances improved. After approximately one year, Respondent was owed a substantial sum in deferred salary and accepted an ownership interest in the clinic in payment.

5. Respondent testified that he entered into a delegation of services agreement with Dr. Helston, and that the physician had practice protocols and a medication formulary that were followed in the clinic. Office manager Cathy Miller corroborated that the protocols and drug formulary were maintained in books in the office.

6. a. Respondent presented a document entitled "Delegation of Services Agreement Betwee[n] Supervising Physician and Physician Assistant (Title 16, CCR, Section 1399.540," which he and Dr. Helston executed on October 7, 2002, as the document that was in effect during his employment. The agreement required respondent to "always and immediately" consult with Dr. Helston in the following circumstances: "patient's failure to respond to therapy; physician assistant's uncertainty of diagnosis; patient's desire to see physician; any condition which the physician assistant feels exceeds his ability to manage." (Exh. C.) Authorized services, supervision, and chart review were set with reference to California Code of Regulations (CCR), title 16, section 1399.541.

b. The agreement contains the following requirements under the heading of "Medical Devices and Physician's Prescriptions": "The PA may transmit by telephone to a pharmacist, and orally or in writing on a patient's medical record or other transmittal device to a nurse or other medical entity[,] the supervising [physician's] order for medication or medical device requiring a prescription in accordance with subsection (h) of Section 1399.541 of the Physician Assistant Regulations." (Exh. C.)

7. Respondent and Dr. Helston regularly met to discuss patients and review files, typically at the end of the day. The only patient chart received in evidence, that of J.M., contains Dr. Helston's signature on all progress notes of dates in which Respondent saw the patient. Respondent and Dr. Helston also discussed the medication orders at the end of the day, but they did not always specifically discuss when a controlled substance was prescribed for a patient before the prescription was actually called or faxed to the pharmacy.

8. Dr. Helston, who was in his 70s, closed the practice in or about March 2007.

Patient J.M.

9. J.M., a man born on October 8, 1965, had been Dr. Helston's patient at least since 1999. The patient's chart was received in evidence, although without a copy of its hard cover or "jacket." Respondent testified without contradiction that it was Dr. Helston's custom and practice, which he directed Respondent and others in the office to follow, to write the established diagnoses and recurrent medications on the inside cover of the chart jacket. Respondent referred to these as "chronic" diagnoses and medications, and having them on the chart jacket was intended for ease of reference and better management of the patient. Respondent recalls that information regarding J.M.'s diagnoses and medications was recorded in the patient's medical chart, and that by the time he first saw the patient Dr. Helston had written a number of diagnoses and regular medications.

10. As it pertains to this matter, Respondent testified, with support from the patient record, that Dr. Helston had already diagnosed alcohol abuse, anxiety, and depression by the time Respondent first saw the patient. On January 25, 2001, for instance, Dr. Helston diagnosed the patient with "agitated depression," and prescribed the anti-depressant Zoloft. On August 13, 2001, Dr. Helston diagnosed "chronic anxiety syndrome," and again prescribed Zoloft.

11. On October 25, 2001, Dr. Helston charted diagnoses of chronic sprain, insomnia, and "compulsive alcoholism." The physician prescribed Antabuse to treat the alcohol dependence. He also prescribed Restoril, a benzodiazepine used to treat insomnia, and warned against taking the medication with alcohol. On November 26, 2001, Dr. Helston noted diagnoses of "chronic alcoholism," depression, and insomnia, and prescribed Antabuse, Restoril, Valium, and Zoloft. On April 10, 2002, Dr. Helston set forth the diagnosis of "anxiety depression," and prescribed Zoloft. On June 5, 2002, he wrote "chronic depression" as one of the diagnoses, and prescribed Restoril. He also prescribed Vicodin for pain associated with musculoskeletal conditions.

12. Respondent's first encounter with J.M. occurred on November 12, 2003. On that date, the patient came to the doctor's office for a refill of his medications. He was taking Vicodin and Seroquel, an antipsychotic drug. Respondent conducted a physical examination before refilling the medications. Respondent set forth in the chart two of the established diagnoses for which the medications had been initially prescribed by Dr. Helston, sciatica and depression, respectively.

13. a. The patient returned for medication refills on December 11, 2003, and was again seen by Respondent. The patient asked for a change in Seroquel, as it was "too much." Respondent wrote that the patient had a history of anxiety and sciatica. He conducted a physical examination, and ordered some laboratory tests and an electrocardiogram. He charted the existing diagnoses of "bipolar depression," sciatica, herniated disc, and shortness of breath. Respondent prescribed[3] the antidepressant Wellbutrin, Valium, and Vicodin.

b. Respondent denied making any new diagnoses on this visit. Rather, he testified that depression was one of the diagnoses that Dr. Helston had established for the patient. He did not diagnose bipolar disorder, but used the term "bipolar" to refer to a type of depression that has periods of euphoria. On cross-examination, Steven M. Star (Star), complainant's expert, agreed that depression could be characterized as "bipolar" if the patient experienced periods of euphoria.

c. With respect to the Valium prescription, Respondent testified that Dr. Helston had previously prescribed Valium, despite the diagnosis of alcohol abuse, as part of his treatment of the patient. Respondent asserted that he was merely continuing the supervising physician's regimen.

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[3] Consistent with section 3502.1, subdivision (b), references to "prescription" are synonymous with references to "drug order" in the context of physician assistant practice.

14. Respondent refilled the Wellbutrin, Valium, and Vicodin prescriptions following a patient visit on December 30, 2003. Dr. Helston saw the patient on February 3, 2004, noted diagnoses of herniated disc, sciatica, and anxiety/depression, and refilled J.M.'s medications. Respondent saw the patient on March 3, 2004. He diagnosed sinusitis, bronchitis, and chest congestion, prescribed medication for the upper respiratory condition, and refilled the Wellbutrin, Valium, and Vicodin prescriptions.

15. Respondent saw the patient on his next visit, on April 2, 2004. J.M. was in the doctor's office for medication refills. In the history of present illness section of the chart, Respondent wrote that the infection had resolved and that there was improvement in the depression. Respondent refilled the Seroquel and Vicodin prescriptions.

16. On July 4, 2004, J.M. was taken to the emergency room at Kern Medical Center after his wife reported that he may have overdosed on baclofen, a muscle relaxant, and diazepam, the generic component found in Valium. On arrival to the hospital, J.M. was oriented to name and place and denied suicide ideation. J.M. reported that he had taken 80 pills of Valium over the prior two weeks. While in the emergency room, J.M. became agitated, and was subsequently admitted for altered mental status due to an overdose with benzodiazepine and possibly baclofen. Urine testing was positive for benzodiazepine. Bilateral diffused wheezes were noted on physical exam. J.M. received intravenous fluids and oxygen via a nasal cannula. J.M. was discharged on July 7, 2004, without a specific discharge diagnosis. He was prescribed Seroquel, Lexapro, Pepcid, and Combivent inhaler. The patient was counseled to quit alcohol and smoking and directed for follow-up with his primary care physician.

17. a. Respondent saw the patient on July 8, 2004. He wrote on the medical chart, based on J.M.'s report, that the patient had "[overdosed] on Baclofen – forgot he had already taken." On examination, J.M. was alert, oriented, and in no apparent distress. His mental status appeared normal. Nevertheless, because of the reported overdose, Respondent diagnosed "rule out overdose." Respondent discontinued the Valium and the Seroquel.

b. Respondent testified that he told the nurse to obtain the hospitalization records. This testimony was not contradicted, but Respondent did not write in the patient's chart his efforts to obtain the records, a pertinent fact. In addition, Respondent did not document that J.M. had been treated at the hospital on July 5, 2004, also a pertinent fact.

c. Complainant did not present any expert testimony regarding the records other medical providers keep in similar circumstances, and, therefore, did not establish that Respondent deviated from the standard of care in failing to document the items set forth in factual finding number 17b.

18. Dr. Helston saw the patient on July 28, 2004. The patient's chief complaint was that he wanted a medication change. Dr. Helston noted diagnoses of sciatica, insomnia, anxiety/depression, and tobacco addiction. Dr. Helston reinstated the Valium prescription, and prescribed Restoril, Vicodin, and Wellbutrin.

19. On his next visit, on August 13, 2004, J.M. complained of lumps in his forearm and requested a change in his medications. Respondent diagnosed and treated the skin condition, and prescribed Restoril for insomnia.

20. The patient returned on September 7, 2004, for medication refill, and was again seen by Respondent. J.M. reported that he was feeling better, but that he had back pain. After his physical examination of the patient, Respondent wrote the diagnoses of "anxiety depression" and "low back pain." He prescribed Valium, Vicodin, and Wellbutrin.

Additional Findings Regarding the Standard of Care.

21. Star testified that Respondent deviated from the standard of care in several respects. On the patient's visits on November 12 and December 11, 2003, and September 7, 2004, Star opined that Respondent diagnosed depression, Bipolar Disorder, and anxiety, without appropriate evaluation and that Respondent failed to document the basis for the diagnoses. Respondent denied making new diagnoses, and asserted he had merely charted diagnoses established by Dr. Helston and contained in the chart. Respondent's testimony is supported by the entries in the patient's chart, and his opinion that he acted within the standard of care is persuasive. Dr. Helston had derived the diagnoses in question and prescribed the treatment plans that Respondent followed. Dr. Helston's diagnostic impressions or treatment plans were not challenged at the hearing. Of note, in each of the visits in question the patient presented for medication refills, and presented no new complaints; Respondent refilled the medications and restated the conditions that were being treated by the medications in question. Accordingly, deviations from the standard of care were not established.

22. Star also opined that Respondent failed to document J.M.'s history of alcohol abuse during any of the visits set forth above. Respondent countered that the patient's alcohol abuse, including Dr. Helston's treatment for the condition, was well-documented in the file and he did not need to duplicate the information. Star agreed that Respondent did not need to repeat the patient's history on each visit, but that Respondent failed to provide an adequate history of this problem on any visit. Respondent's testimony is persuasive. Respondent did not provide treatment for any complaint of alcohol-related problems. Nevertheless, Respondent was aware of the patient's history, which history was adequately documented in the chart. Star did not deem the entire chart inadequate, and focusing on a few of the patient's visits contradicts his own testimony that the history of alcohol abuse need not be repeated each time. Therefore, a deviation from the standard of care was not established.

23. Star also testified that Respondent prescribed Valium for the patient on several occasions, despite the patient's alcohol abuse. However, Valium was one of the medications Dr. Helton was prescribing, concurrent with his treatment of the patient's alcohol abuse. Respondent merely continued the supervising physician's plan, and there is no evidence that new or additional symptoms occurred at any time Respondent prescribed Valium. In fact, on July 8, 2004, Respondent declined to refill the Valium prescription after the purported suicide attempt, only to have Dr. Helston reinstate the medication on the patient's July 28, 2004 visit. A deviation from the standard of care was not established.

24. Star opined that Respondent further deviated from the standard of care by treating J.M. even though he did not have a delegation of authority from Dr. Helston. The opinion was based on the fact that Star had not received the pertinent document(s) during the investigation. However, the evidence at the hearing was to the contrary, as set forth in factual finding numbers 4 through 7.[4]

25. a. Star testified that the controlled substance prescriptions set forth in factual finding numbers 12, 13, 14, 15, 19, and 20 each required patient-specific approval by Dr. Helston. This opinion was not directly contradicted, and is consistent with the requirements of section 3502.1, subdivision (c)(2). Star's opinion is credited and establishes the standard of care.

b. The chart references to the controlled substances, and the absence of any chart notation that the prescriptions had been specifically discussed with the supervising physician, lead to the reasonable inference that Respondent prescribed the controlled substances without specific discussion with Dr. Helston about the prescriptions before their transmittal to a pharmacy for filling. The fact that the practice was for Respondent and Dr. Helston to review the charts at the end of the day when the patient had likely left the office further supports such inference. Respondent did not present any specific evidence that he had discussed the specific controlled substance recommendations with the physician. Respondent therefore violated the standard of care by failing to obtain Dr. Helston's specific approval before issuing the drug order.

c. Star further testified that the deviation was extreme, which testimony was not contradicted by other expert opinion.

Patient M.W.

26. Respondent began working for US HealthWorks (USH) in May 2007, following the closure of Dr. Helston's practice. He attended a one-week training session in the Riverside facility of the company before starting his assignment in the Bakersfield office.

27. M.W., a 51-year-old woman at the time, presented to USH on July 24, 2007, for a pre-employment physical examination. A female medical assistant accompanied M.W. to the examination room, and asked her to remove all her clothes with the exception of her bra and panties, and to wear a gown. M.W. did as she was told. The gown was her knee-length and tied in the back. The room measured approximately six feet by ten feet, had an examination table, a counter, and a rolling stool for the physician to sit.

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[4] Star was unavailable on the last day of hearing to provide rebuttal testimony regarding the document submitted into evidence. In any event, Respondent was accused of not having any delegation of authority, not of having a delegation that was deficient in a specific, charged, manner.

28. a. After a few minutes, Respondent, whom M.W. had never met, entered the room and closed the door. The patient recalled the encounter as follows. Standing behind her, Respondent asked M.W. to stretch, touching her toes with her hands. He then asked the patient to sit at the table, and began examining her.

b. On direct examination, M.W. stated that as part of the physical examination Respondent attempted to place his hand in her chest area through the top of the gown. She pulled back, but Respondent tried again. M.W. pulled back again, and Respondent did not make a third attempt. Respondent was able to touch part of her chest, and M.W. believed that he was attempting to touch her breasts. On cross-examination, M.W. added that Respondent had a stethoscope in his hand, and that he was trying to place the instrument in her chest over the top of the gown.

c. Respondent later examined her midsection, while the patient was in a seated position. It was during this examination that, M.W. testified, Respondent touched her vaginal area, over the gown and panties, about three times. M.W. described the touching as a "poking." M.W. did not complain because she believed that the touching may have been accidental.

d. M.W. described the next part of the examination as involving the touching of her legs, "up and down," during which Respondent again purportedly touched her vaginal area.

e. At the conclusion of the examination, Respondent said something about the fact that the pre-employment physical examination did not include breast examination or a pap smear, but that it may in the future.

f. On cross-examination, M.W. denied that Respondent had listened to her heart or examined her knees or lower back.

29. M.W. testified that she did not say anything to Respondent about the touching she felt was inappropriate because she was afraid of failing the physical examination. She did report the matter the following day to USH office manager Liz Martinez (Martinez). Martinez later asked M.W. to write an incident report, which she did.

30. On August 30, 2007, the patient filed a complaint with the Board. The two-page written incident report was generally consistent with her testimony, except that M.W. referred to Respondent touching her "groin area" instead of the vaginal area. She also referred to Respondent placing the stethoscope inside the gown to listen to the heart, which she felt was "creepy," and did not specifically refer to his hand.

31. a. Respondent did not have specific recollection of M.W., but denied touching her inappropriately. He described his typical examination, which does not include any touching of the groin area, and testified, with the assistance of the physical examination record prepared at the time, that he performed his typical examination.

b. It is his custom and practice to commence with the examination of a patient's head and to work his way down other parts of the body. He places the stethoscope in contact with the skin in order to properly hear the heart, a practice that Star agreed was consistent with the standard of care. Because the gowns provided at USH are tied at the neck, Respondent tries to insert the stethoscope through the neck area for contact with the skin, while he places one finger over the instrument outside the gown. Respondent does so instead of the more intrusive removal of gown and bra.

c. Respondent next examines the patient's abdomen. He examined M.W. while she was in a seated position. While the examination is typically performed in the supine position, Respondent felt he could do an adequate job while the patient was in the seated position and cited a statement in the authoritative DeGowin's Diagnostic Examination (Eighth Edition) in support of his decision. The decision to conduct the abdominal examination in the seated position is consistent with Respondent's other testimony about the characteristics of the pre-employment physical, namely, that is not as comprehensive as a full physical, that absent significant pathology the examiner is there to help the prospective employee, and that his employer pressured him to complete the examinations in less than ten minutes.

d. Respondent typically palpates each quadrant of the abdomen in a systematic fashion in order to assess if there are masses or other pathology. He uses his fingertips, presses, and asks if there is any tenderness. His palpation of the lower abdomen may reach the suprapubic area, but does not reach as far as the groin area.

e. Respondent then taps the lower back to probe for kidney tenderness. His muscoskeletal examination follows, and he presses and manipulates the various muscles and structures to uncover any problems. Respondent also typically tells his female patients that the pre-employment examination is not a substitute for their yearly physical examination and that they should see their physicians for breast examinations and pap smears.

f. Respondent pointed to the physical examination record to indicate that he performed his usual examination. He wrote in the form that the following were normal: skin; lymphatics; head and neck; eyes; ears; nose; moth, tongue, throat; teeth; chest and lungs; heart and abdominal pulses; abdomen; hernia; shoulder, arm and hand; hip, knee, and ankle; feet; back and spine; neurological; emotional status; and other. He concluded that the patient was "Medically acceptable for the position offered."

32. a. No female chaperone was present during respondent's examination of M.W. It was unclear why there was no chaperone during the examination. USH facility office manager Martinez and area medical director Alesia Wagner, D.O. (Wagner), both testified that it was USH's policy to strongly recommend a chaperone of all gowned female patients. Martinez testified that a board containing patients to be chaperoned was posted in the nursing area. However, she did not state when the board was first installed and did not provide details regarding how chaperones were chosen or assigned. Dr. Wagner believed that the physician in the Bakersfield office, Kamal Eldrageely, M.D. (Eldrageely), had directed Respondent to use a chaperone when examining female patients.

b. Respondent denied receiving any directive on chaperone use from Dr. Eldrageely, and denied that chaperones were regularly used at the office. During his May 2007 training at a USH facility in Riverside, Respondent was told that chaperones were not regularly used by USH. In the Bakersfield office, there were back office female assistants, but they had specific duties, such as lab or x-ray technicians, and were not always available to serve as chaperones. Respondent did have a conversation with Martinez, which he believes occurred after the M.W. examination, in which he was told a board would be used to designate which patients would be seen with a chaperone.

c. Star testified that failure to have a chaperone present constituted a deviation from the standard of care. However, despite this testimony, the Accusation does not contain any charge pertaining to the absence of a chaperone during M.W.'s examination. More importantly, in the absence of details regarding the reason(s) for the absence of a chaperone, including whether the examination was designated or flagged as one requiring a chaperone, whether a chaperone was available, and whether the chaperone assignment was Respondent's responsibility, no adverse inference or nefarious intent will be imputed to Respondent because a chaperone was not present.

33. Respondent presented with good demeanor, and provided direct and matter-of-fact testimony. Respondent's testimony that he performed his usual pre-employment physical examination is supported by the medical record. Respondent's denial of any inappropriate touching was credible. Significantly, M.W. herself corroborated key parts of his testimony. Respondent candidly described that he inserts the stethoscope through the gown to make contact with the skin. Respondent's testimony that he drops only the stethoscope through the top of the gown is likely to be true, given the physical limitations presented by a gown tied at the neck. The lower abdominal palpation described by Respondent is consistent with M.W.'s description of "poking." Further, given the brief time consumed by the examination and the head-to-toe nature of the examination, it is unlikely that Respondent had time for any intentional touching of a sexual nature. In the existing circumstances, therefore, M.W.'s testimony is insufficient to establish that Respondent touched her in an inappropriate sexual manner.

Criminal Plea

34. a. On June 27, 2008, a criminal complaint was issued accusing Respondent of violating Penal Code section 243.4, subdivision (c) (sexual battery with fraudulent representations of medical necessity), a felony (count 1), and section 243.4, subdivision (e)(1) (sexual battery), a misdemeanor (count 2). Count 2 states: "On or about July 24, 2007, David Ortiz, did willfully and unlawfully touch an intimate part of [M.W.], against the will of said person with the specific purpose of sexual arousal, sexual gratification or sexual abuse, in violation of Penal Code section 243.4, subdivision (E)(1)." (Exh. 11, at p.11.)

b. Respondent explained that he entered into a plea to the charges on the advice of his attorney. Respondent was represented in the criminal case by Greene and others in his office, including Casa. During a conversation in the attorneys' office, Casa recommended

that Respondent plead "no contest." Casa further explained that if he did not get into trouble for two years the matter would go away. Respondent asked if pleading "no contest" was like pleading guilty. As Respondent recalled, Casa was "emphatic" that it was not like pleading guilty. Casa said the plea would be better because the case would disappear. Casa told Respondent that there was always the small possibility that he could lose the case, so it was better to take the plea. Casa also reported having discussed the matter with the judge, and that the plea terms were acceptable. Respondent testified that he authorized his attorney to enter a plea of no contest and that he would not have authorized him to enter a guilty plea on his behalf.

c. Respondent was also concerned about the impact continuing proceedings would have on his finances and his employment opportunities. He was not working at the time of the discussion with Casa, and lacked the funds to proceed to trial. In addition, he was looking for employment and did not want potential employers or others to read about his case in the newspapers.

d. Respondent's testimony was corroborated by the docket in the criminal matter. Respondent was not present during any of the ten pre-guilty-plea court hearings in his criminal case, and Greene or one of his associates entered an appearance on Respondent's behalf each time. On February 4, 2009, Casa entered a plea of guilty to one of the two counts, number 2, for violation of Penal Code section 243.4, subdivision (e)(1) (sexual battery). The docket states that "Defendant through his attorney is advised of these following rights and all are waived." (Exh. G., at p. 9.) Sentencing was set for February 7, 2012, as was a hearing on conditional dismissal of the case. As set forth in the docket, "Case to be dismissed if there are no further violations of the law." (Exh. G., at p. 9.)

e. On February 7, 2012, Respondent was present in the Superior Court, Metropolitan Justice Building, County of Kern, and was represented by Greene. The court docket contains the following entry: "[T]he court makes the following findings and/or orders: [¶] Motion to withdraw guilty plea is granted. Not Guilty plea entered as to Count 2. [¶] Count 2 dismissed on motion of the District Attorney. Reason for dismissal or discharge: furtherance of justice (PC 1385). [¶] . . . [¶]" (Exh. G, at p. 10.)

f. Respondent's testimony at the hearing on remand was consistent with his testimony at the initial hearing, albeit more detailed. He continued to present good demeanor, his answers were internally consistent, and his testimony was independently corroborated by the information in the court docket.

g. Respondent's testimony clearly and persuasively establishes that he did not intend to admit guilt and that he did not believe he was entering a guilty plea. Respondent did agree to plead no contest on advice of counsel because he believed that he would not be admitting guilt, because he was told the case would go away without adverse consequences, and because he wanted to avoid the negative impact of a trial, including the adverse publicity, the expenditure of unavailable funds, and the possibility that he may lose. Pursuant to the plea agreement, the criminal court deferred imposing any penalty, which indicates that neither the prosecutor nor the court believed Respondent was a sexual predator or that he warranted

immediate punishment. On February 7, 2012, the guilty plea was in fact withdrawn, a not guilty plea was entered, and Count 2 was dismissed. In the existing circumstances, the February 9, 2009 guilty plea is given little or no weight and is insufficient, even with the testimony of M.W., to overcome Respondent's contrary testimony that he did not inappropriately touch M.W.[5]

h. Complainant argued that it was not reasonable for Respondent to believe that the matter would simply go away, that he would be permitted to plead no contest, or that he would not be admitting to the underlying facts. On the contrary, it was reasonable for someone not having been previously involved with the criminal system to rely on his attorney's advice. In fact, Respondent credibly testified that Casa was "emphatic" on his recommendation. Moreover, Respondent's understanding of his attorney's explanation is not too far from what actually happened, a deferred entry of judgment followed by dismissal of the charges.

Uncharged Allegations Involving Other Patients[6]

35. About three to four years ago, A.M. accompanied her grandmother, who had complaints of back pain, to Dr. Helston's office. After examining the 60-something patient, Respondent provided an explanation of the problem. As A.M. recalled, during the explanation Respondent used her as a model. He allegedly touched A.M.'s breasts to make a statement about the problems for shorter, bustier, and heavier women. A.M. felt uncomfortable, but did not say anything. Respondent did not recall seeing A.M. and did not know who her grandmother was. While Respondent may have more appropriately made his point with the use of words or a model, it was not established that he touched A.M. for his sexual gratification.

36. a. C.N., a front office employee of Dr. Helston, testified that in the latter part of 2002 she complained of neck and back pain, and asked Respondent if he could look into it and possibly relieve the pain. Respondent agreed to examine her. He applied pressure to the neck and shoulders. As part of the examination, Respondent allegedly removed C.N.'s blouse and bra and touched her breasts. On cross-examination, C.N. recalled that Respondent had her

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[5] As a matter of law, now that the guilty plea has been withdrawn, it cannot be relied upon. (Ev. Code, § 1153 ["Evidence of a plea of guilty, later withdrawn, or of an offer to plead guilty to the crime charged or to any other crime, made by the defendant in a criminal action is inadmissible in any action or in any proceeding of any nature, including proceedings before agencies, commissions, boards, and tribunals."]; *Ryan-Lanigan v. Bureau of Real Estate* (2013) 222 Cal.App.4th 72, 582, 589; see also *In re Sutherland* (1972) 6 Cal.3d 666, 671-672 [the *status quo ante* is restored after the withdrawal of a guilty plea]). Nevertheless, factual findings and conclusions of law have been made as directed by the Court and by the Board.

[6] Complainant was permitted to introduce evidence of uncharged alleged sexual misconduct involving three other former patients, A.M., C.N., and D.S., pursuant to Evidence Code section 1101, subdivision (b), and *People v. Ewoldt* (1994) 7 Cal.4th 380, to establish that the charged sexual misconduct involving M.W. occurred because it was part of a plan or design that included the uncharged acts.

move her arms and was able to reproduce the pain. C.N. also recalled being asked if she had chest pains, and she denied having them. C.N. testified that Respondent told her that her breasts were heavy and causing strain. He gave her an ice pack and recommended a pain reliever. No patient chart was available at the hearing.

b. Respondent denied that C.N. was a patient, and referred to her as a fellow employee. He noted that all employees receive some free medical care at some point. As her request, Respondent had examined her legs on a couple of occasions, once after a fracture. On another occasion, C.N. complained of chest pains, around her left breast. Respondent examined her left breast, and reported there was no pathology. He suspected a muscular problem, and had C.N. lift her arm. She was able to reproduce the pain and he suggested treatment.

c. The evidence established that Respondent examined C.N.'s left breast, but if his testimony is credited, he did so for a valid medical reason. In light of Respondent's plausible explanation, and absent other basis to disregard his testimony, the testimony of C.N. is insufficient to establish that Respondent fondled C.N. or engaged in other inappropriate conduct.

37. a. D.S., J.M.'s wife, was also a patient of Dr. Helston. D.S., who was in a wheelchair as a result of an accident, testified that Respondent was too "touchy feely." As examples, she stated that he patted or massaged her hands, shoulders, or legs, as she came in, asking how she was doing. J.M. was usually with her, and neither he nor she complained about the alleged touching.

b. Respondent recalled seeing D.S. on two occasions, and conducted an examination only once. She presented for a medication refill, but her insurance no longer covered visits to Dr. Helston. As a courtesy, Respondent agreed to refill the medications, but told D.S. she would have to go to her new doctor next time. He conducted a brief physical examination before refilling the medication. The patient returned one month later and, as Respondent recalled, became very upset when her medications could not be refilled.

c. It was not established that Respondent engaged in any inappropriate conduct toward D.S. Her general testimony does not show that Respondent's contact was anything but brief, non-sexual, physical contact in an apparent attempt to greet the patient or to place her at ease.

38. The uncharged allegations were not established at the hearing, and thus cannot be said to be part of a plan or design that included inappropriately touching M.W. Moreover, had some or all of the uncharged allegations been established, the claims made by A.M., C.N., and D.S. are sufficiently dissimilar from those made by M.W. that proof of the uncharged acts are not probative of what may have happened with M.W.

Costs of Investigation and Enforcement

39. Complainant incurred costs in the sum of $12,613, in charges from the Attorney General's office. In light of the allegations established at the hearing, ten percent of the actual costs, or $1,261, constitutes the reasonable costs of investigation and enforcement.

LEGAL CONCLUSIONS

1. Complainant bears the burden of proving, by clear and convincing evidence to a reasonable certainty, that cause exists to discipline respondent's license. (*Ettinger v. Board of Medical Quality Assurance* (1985) 135 Cal.App.3d 853, 856; *James v. Board of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1104.) This means that the burden rests on complainant to establish the charging allegations by proof that is clear, explicit and unequivocal –so clear as to leave no substantial doubt, and sufficiently strong to command the unhesitating assent of every reasonable mind. (*In re Marriage of Weaver* (1990) 224 Cal.App.3d 478.) Complainant has only satisfied this high burden of proof as set forth in legal conclusion numbers 2 and 3.

2. Cause exists to discipline Respondent's license pursuant to sections 2234, subdivision (b), and 3527, subdivision (a), in that he engaged in gross negligence in connection with his care and treatment of J.M. by failing to obtain patient-specific authorization from Dr. Helston for several controlled substance prescriptions, by reason of factual finding numbers 12, 13, 14, 15, 19, 20, and 25.

3. Cause exists to discipline Respondent's license pursuant to sections 3502, subdivision (a), and 3502.1 in that he prescribed controlled substances to J.M. without first obtaining patient-specific authorization from Dr. Helston to prescribe the medications, by reason of factual finding numbers 12, 13, 14, 15, 19, 20, and 25.

4. Cause does not exist to discipline Respondent's license pursuant to sections 3502 or 3502.1 in that it was not established by clear and convincing evidence, except as set forth in legal conclusion number 3, that Respondent did not have the authority to provide care and treatment to J.M., by reason of factual finding numbers 4, 5, 6, 7, and 24.

5. Cause does not exist to discipline Respondent's license pursuant to sections 2266 and 3527, subdivision (a), in that it was not established by clear and convincing evidence that he failed to maintain adequate records in connection with the care and treatment provided to J.M., by reason of factual finding number 17.

6. Cause does not exist to discipline Respondent's license pursuant to section 726 in that it was not established by clear and convincing evidence that he engaged in acts of sexual misconduct, by reason of factual finding numbers 26 through 38.

7. Section 2234, subdivision (c), authorizes the discipline of a license for repeated negligent acts, and, states: "To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts. . . ." Inasmuch as the established violations, as set forth in factual finding numbers 12, 13, 14, 15, 19, 20, and 25, all involved the same deviation from the standard of care, namely, failure to obtain patient-specific authorization to issue controlled substance drug orders, and not separate and distinct departures from the standard, cause does not exist to discipline Respondent's license pursuant to sections 2234, subdivision (c), and 3527, subdivision (a), for repeated negligent acts.

8. Cause does not exist to discipline Respondent's license pursuant to sections 2242 or 3527 in that it was not established, by clear and convincing evidence, that he prescribed medications for J.M. without medical indication, by reason of factual finding numbers 9 through 24.

9. Cause does not exist to discipline Respondent's license pursuant to sections 725, 2242, or 3527, in that it was not established, by clear and convincing evidence, that he excessively prescribed medications to J.M., by reason of factual finding numbers 9 through 24.

10. The reasonable costs of investigation and enforcement pursuant to section 125.3 are $1,261, by reason of factual finding number 39, and legal conclusion numbers 2, 3, and 5.

11. In light of the violations established, the order that follows is necessary and sufficient for the protection of the public. While Respondent engaged in gross negligence by prescribing controlled substances to J.M. without first obtaining specific authorization from Dr. Helston, there are significant mitigating factors. Respondent issued the prescriptions consistent within the supervising physician's general if not specific treatment plan for the patient. Moreover, Respondent regularly discussed the patient's care with the physician and the supervisor ratified Respondent's actions. These factors justify deviation from the level of discipline in the Board's Disciplinary Guidelines.

Moreover, given the new evidence submitted on remand and the lack of cause for discipline based on Respondent's recordkeeping, revocation of Respondent's license is not warranted for the protection of the public. The fact that the plea has been withdrawn is another reason not to revoke Respondent's licensee. A period of Board monitoring continues to be appropriate in light of the established violations.

ORDER

Physician Assistant License No. PA-11186 issued to Respondent David Ortiz, is hereby suspended for six months. However, the suspension is stayed and Respondent's license is placed on probation for three years upon the following terms and conditions.

1. Approval of Supervising Physician. Within 30 days of the effective date of this decision, Respondent shall submit to the Board or its designee for its prior approval the name and license number of the supervising physician and a practice plan detailing the nature and frequency of supervision to be provided. Respondent shall not practice until the supervising physician and practice plan are approved by the Board or its designee.

Respondent shall have the supervising physician submit quarterly reports to the Board or its designee.

If the supervising physician resigns or is no longer available, Respondent shall, within 15 days, submit the name and license number of a new supervising physician for approval.

2. Notification of Employer and Supervising Physician. Respondent shall notify his current and any subsequent employer and supervising physician(s) of the discipline and provide a copy of the Decision and Order to each employer and supervising physician(s) during his period of probation, at onset of that employment. Respondent shall ensure that each employer informs the Board or its designee, in writing within 30 days, verifying that the employer and supervising physician(s) have received a copy of the Decision and Order.

3. Obey All Laws. Respondent shall obey all federal, state, and local laws, and all rules governing the practice of medicine as a physician assistant in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

4. Quarterly Reports. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board or its designee, stating whether there has been compliance with all the conditions of probation.

5. Other Probation Requirements. Respondent shall comply with the Board's probation unit. Respondent shall, at all times, keep the Board and probation unit informed of Respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Board and probation unit. Under no circumstances shall a post office box serve as an address of record, except as allowed by California Code of Regulations section 1399.523.

Respondent shall appear in person for an initial probation interview with the Board or its designee within 90 days of the decision. Respondent shall attend the initial interview at a time and place determined by the Board or its designee.

Respondent shall, at all times, maintain a current and renewed physician assistant license.

Respondent shall also immediately inform probation unit, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 days.

6. Interview with Medical Consultant. Respondent shall appear in person for interviews with the Board's medical or expert physician assistant consultant upon request at various intervals and with reasonable notice.

7. Tolling for Out-of-State Practice or Residence. The period of probation shall not run during the time Respondent is residing or practicing outside the jurisdiction of California. If, during probation, Respondent moves out of the jurisdiction of California to reside or practice elsewhere, including federal facilities, Respondent is required to immediately notify the Board in writing of the date or departure, and the date or return, if any.

Respondent's license shall be automatically canceled if Respondent's period of temporary or permanent residence or practice outside California totals two years. Respondent's license shall not be canceled as long as Respondent is residing and practicing as a physician assistant in another state of the United States and is on active probation with the physician assistant licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

8. Failure to Practice as a Physician Assistant –California Resident. In the event Respondent resides in California and for any reason Respondent stops practicing as a physician assistant in California, Respondent shall notify the Board or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve Respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding 30 calendar days in which Respondent is not practicing as a physician assistant.

All time spent in a clinical training program that has been approved by the Board or its designee, shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board ordered suspension or in compliance with any other condition or probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically canceled if, for a total of two years, Respondent resides in California and fails to practice as a physician assistant.

9. Unannounced Clinical Site Visit. The Board or its designee may make unannounced clinical site visits at any time to ensure that Respondent is complying with all terms and conditions of probation.

10. Condition Fulfillment. A course, evaluation, or treatment completed after the acts that gave rise to the charges in the accusation but prior to the effective date of the decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of the condition.

11. Completion of Probation. Respondent shall comply with all financial obligations (e.g., cost recovery, probation costs) no later than 60 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's license will be fully restored.

12. Violation of Probation. If Respondent violates probation in any respect, the Board after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. Cost Recovery. Respondent is hereby ordered to reimburse the Committee the amount of $1,261 for its investigative costs during the period of probation, while employed, on a payment plan approved by the Board. Failure to reimburse the Board's costs of its investigation shall constitute a violation of the probation order, unless the Board agrees in writing to payment by an installment plan because of financial hardship. The filing of bankruptcy by the Respondent shall not relieve the respondent of his responsibility to reimburse the Board for its investigative costs.

14. Probation Monitoring Costs. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. The costs shall be made payable to the Board and delivered to the Board no later than January 31 of each calendar year.

15. Voluntary License Surrender. Following the effective date of this probation, if Respondent ceases practicing due to retirement, health reasons, or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request the voluntary surrender of Respondent's license to the Board. The Board reserves the right to evaluate the Respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 days deliver Respondent's wallet and wall certificate to the Board or its designee and shall no longer practice as a physician assistant. Respondent will no longer be subject to the terms and conditions of probation and the surrender of Respondent's license shall be deemed disciplinary action. If Respondent re-applies for a physician assistant license, the application shall be treated as a petition for reinstatement of a revoked license.

DATED: 6/3/05

SAMUEL D. REYES
Administrative Law Judge
Office of Administrative Hearings